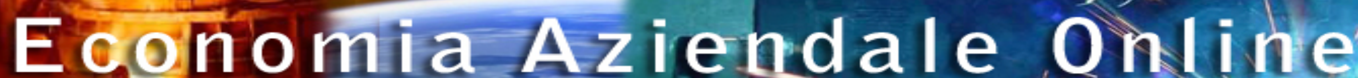


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# Examining Social Trends: Health Care Coverage in the United States. A Contemporary Analysis Through an Historical Lens

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**ABSTRACT**

Understanding the historical road an important policy issue has taken is important not just as a theoretical exercise in public policy formation but also as a (hopefully) useful prescriptive tool to identify and anticipate obstacles moving forward to suggest realistic, concrete alternatives for progressive reform. This is especially true today in a country like the United States, where extreme political and ideological polarization often leads to dysfunctional governmental paralysis. The present article examines the health care debate adopting a historical narrative perspective, from the Progressive Era to the Affordable Care Act (Obamacare). The article argues that the history of health care in the U.S. can be usefully viewed as passing through various phases, which were not always linear from a reform perspective, characterized by the political, economic, and ideological context, as well as by certain societal factors such as the power of important stakeholders regarding health care, for example, unions, health care providers, and insurance companies. Underlying the entire discussion is the complex and often misunderstood nature of health care in the country, even among those inside the sector. An explanation of the various types of public and private insurance programs will also be presented as well as a brief look at some key health care statistics.

Comprendere il percorso storico che una questione politica di particolare rilevanza ha intrapreso è significativo non solo come esercizio teorico nella formazione delle politiche pubbliche, ma anche come strumento prescrittivo che (si spera) risulterà utile al fine di identificare e anticipare future sfide, oltre che a suggerire alternative realistiche e concrete per una riforma progressista. Questo è particolarmente vero oggi in un paese come gli Stati Uniti, dove l'estrema polarizzazione politica e ideologica tende spesso a portare a una disfunzionale paralisi governativa. Il presente articolo esamina il dibattito sull'assistenza sanitaria adoperando un metodo narrativo storico, dall'Era Progressista all'Affordable Care Act (Obamacare). L'articolo sostiene che la storia dell'assistenza sanitaria negli Stati Uniti può essere utilmente vista come un passaggio attraverso varie fasi, le quali non si presentano sempre lineari dal punto di vista delle riforme, ma sono caratterizzate

dal contesto politico, economico e ideologico, nonché da alcuni fattori sociali come il potere esercitato da stakeholder di rilievo in materia di assistenza sanitaria (inclusi sindacati, fornitori di assistenza sanitaria e compagnie di assicurazione). Alla base del dibattito giace la natura complessa e spesso fraintesa dell'assistenza sanitaria statunitense, anche tra gli addetti ai lavori. L'articolo presenta, in ultimo, una spiegazione delle varie tipologie di programmi assicurativi pubblici e privati, offrendo al contempo uno sguardo ad alcune statistiche chiave relative all'assistenza sanitaria.

**Keywords:** Progressive Era, Medicare, Medicaid, Health Maintenance Organization, Preferred Provider Organization, Point of Service plans, Patient Protection and Affordable Care Act, Employee Retirement Income Security Act (ERISA), the Great Society, American Hospital Association, American Medical Association, the Social Security Act, Medicare Advantage, Children's Health Insurance Program (CHIP), Health Insurance Marketplace, American Association of Labor Legislation (AALL), American Federation of Labor.

## 1 – Introduction

The health care system in the U.S. is generally more complex and difficult to decipher than most of its Western counterparts. The simple explanation for this is the lack of a national health care system in the U.S. that provides universal coverage, unlike the situation in most European countries. As a result, health care in the U.S. "can be defined as a mixed system, where government financed Medicare and Medicaid health coverage coexists with privately financed (private health insurance plans) market coverage" (ISPOR, 2023), thus creating more of a "patchwork" system compared to what exists in Western Europe. Amidst all the confusion about how the system works, one commentator nevertheless identifies two certainties: every American hates it and has no clue as to how it works in practice. And the confusion is not only among the beneficiaries of health care but the providers as well. A study in the *Journal of Health Economics* found that "only 14 percent of patients understand even the most basic aspects of their insurance plans" while "only about 37 percent of [doctors] have any real idea how much things are actually supposed to cost" (Mendoza, 2023).

This study looks at the historical evolution of health care in the U.S. to understand why the country has arrived at the present patchwork of available health services. The paper begins with a statistical snapshot of the health care system in the U.S. in terms of the mix of private and public insurance components and the relative weight of each before examining the complicated path health insurance has taken in the U.S., starting with the Progressive Era. A more detailed description of the major programs in the health care landscape is presented followed by a discussion of the political, social, economic, and ideological factors that have accompanied and shaped the succeeding phases in the history of health care in America, often contributing to the discontinuous and halting nature of the historical evolution of health care in the country. The conclusion offers some ideas for future research as well as possible limitations to consider.

## 2 – A brief statistical overview

Before examining the main features of the U.S. health care system and some of its problematic aspects, it is useful to present a brief statistical snapshot of expenditures on health and the extent of coverage. As noted above, a not-insignificant percentage of the U.S. population is covered by government health insurance, in contrast to the perception of many abroad that there is no "socialized" coverage in the U.S. [what is true, however, is that there is no "universal" coverage,

unlike in most OECD countries]. As of 2022, 65.6% of Americans were covered by private insurance plans and 36.1% by public plans. If we break down these numbers further (see Table 1), we see that Medicare and Medicaid (see below for a discussion of these programs) each represented slightly less than 19% of the overall health insurance component, with 3.5% accounted for by the various health insurance programs for Veterans (which are administered by both the Department of Defence and the Veterans Health Administration). The largest segment of the population (54.5%) is covered by employer-based insurance and 10% by direct purchase (private health insurance plans unrelated to employment); 7.9% of the population was uninsured in 2022 (Keisler-Starkey *et al*., 2023). Those who directly purchase health care insurance do so either as part of subsidized marketplace exchanges under the Affordable Care Act (Obamacare) or directly from insurers (Davis, 2023).

**Table 1 – Number and Percentage of People by Health Insurance Coverage Status and Type, 2022 (**Source: U.S. Census Bureau, Current Population Survey, 2022 and 2023 Annual Social and Economic Supplements (CPS ASEC)**)**

| Coverage type, 2022 | Number (in thousands) | Percent |
|---|---|---|
| **Total** | 330.000 | X |
| **Any Health Plan** | 304.000 | 92.1 |
| **Any Private Plan** | 216.500 | 65.6 |
| **Employment-based** | 179.800 | 54.5 |
| **Direct-purchase** | 32.800 | 9.9 |
| **Marketplace coverage** | 11.840 | 3.6 |
| **TRICARE** | 7.817 | 2.4 |
| **Any public plan** | 119.100 | 36.1 |
| **Medicare** | 61.570 | 18.7 |
| **Medicaid** | 62.050 | 18.8 |
| **VA and CHAMPVA** | 3.354 | 1.0 |
| **Uninsured** | 25.940 | 7.9 |

Nevertheless, underscoring the often-baffling nature of health care in the U.S., even the breakdown above is not as transparent as it may seem. There is no neat separation between public and private health care services. In fact, within Medicare, there is an entire category of plans called “Medicare Advantage”, where the government pays people to use private insurance. On the other hand, private insurance is bound by specific government rules and regulations covering costs and types of treatment (Mendoza, 2023).

From a performance perspective, of note is the significantly higher expenditures on health care by the U.S. compared to other OECD countries together with the country’s ranking in terms

of key health and health care measures (see Figure 1 and Tables 2-5. The most recent OECD data (2022) reveals that the U.S. spent nearly 18% of its GDP on health care; the next closest country was Germany at nearly 13%. And per capita spending on health care was almost twice as much in the U.S. as in Germany. In terms of outcomes, the U.S. is at the bottom of the rankings in the following areas: life expectancy, maternal and infant mortality, individuals with multiple chronic conditions; and near the top as regards suicide rates and obesity rates (which are nearly twice the OECD average) (Gunja *et al*., 2023).

**Table 2 – The U.S. is a world outlier when it comes to health care spending 2021 data (or latest available year) (**Source: Gunja *et al.* Online at https://doi.org/10.26099/8ejy-yc74)

| AUS: 10.6%* |
|---|
| CAN: 11.7% |
| FRA: 12.4% |
| GER: 12.8% |
| JPN: 11.1%* |
| KOR: 8.8% |
| NETH: 11.2% |
| NZ: 9.7%* |
| NOR: 10.1% |
| SWE: 11.4% |
| SWIZ: 11.8%* |
| UK: 11.9% |
| US: 17.8% |

**Table 3 – Maternal mortality rate per 100,000 live births, 2020** (Source: KFF analysis of OECD data Get the dataPNG )

| United States: 23.8 |
|---|
| Canada: 8.4 |
| Sweden: 7.0 |
| Germany: 3.6 |
| Japan: 2.7 |
| Austria: 2.4 |
| Australia: 2.0 |
| Netherlands: 1.2 |
| Switzerland: 1.2 |

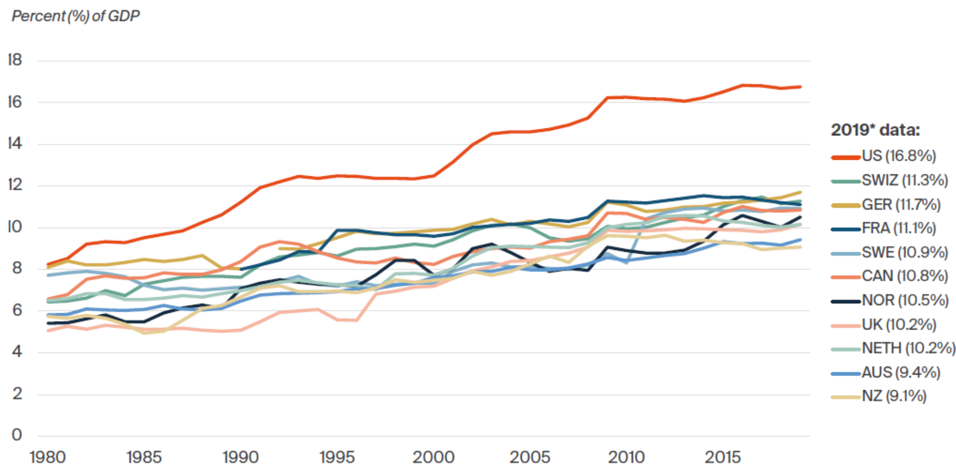



**Fig. 1 – Share of health care spending as a percentage of GDP last 40 years** (Source: from Devpolicyblog 2021)

**Table 4 – Life expectancy in the U.S. compered to other developed countries** (Source: Peterson-KFF Health System Tracker)

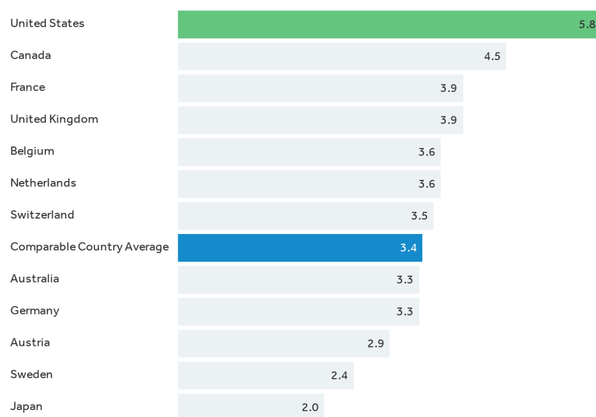
**The U.S. Has the Lowest Life Expectancy Among Large, Wealthy Countries While Far Outspending Them on Health Care**

Life expectancy (2021) and per capita healthcare spending (2021 or nearest year)

| Country | Life expectancy | Health spending, per capita |
|---|---|---|
| United States | 76.1 | $12,318 |
| United Kingdom | 80.8 | $5,387 |
| Germany | 80.9 | $7,383 |
| Austria | 81.3 | $6,693 |
| Netherlands | 81.5 | $6,190 |
| Belgium | 81.9 | $5,274 |
| Comparable Country Average | 82.4 | $6,003 |
| France | 82.5 | $5,468 |
| Sweden | 83.2 | $6,262 |
| Australia | 83.4 | $5,627 |
| Switzerland | 84.0 | $7,179 |
| Japan | 84.5 | $4,666 |

Peterson-KFF Health System Tracker

**Table 5 – Infant mortality in the U.S.: a comparison with other developed countries**



## 3 – A historical review of health insurance in the U.S.: the Progressive Era, the Second World War, and the Social Security Act of 1965

If we take the Progressive Era beginning with Theodore Roosevelt as a starting point, a myriad of political, economic, and social events became the backdrop for the developments that have led to the current health insurance landscape.

The precursors of more modern health insurance plans were the fledgling industrial sickness funds dating to the late 19th century and the workman compensation laws that began at the start of the 20th century. The sickness funds would replace the income a worker lost due to sickness and in some cases provide medical benefits (Murray, 2008). It was the Great Depression, however, that represented a convenient watershed in the history of health insurance in the U.S. This period marked the start of commercial health insurance and employer-sponsored health plans (Lichtenstein, 2022). Like most businesses in the country, hospitals were affected by the inability of many Americans to pay for their services due to economic hardship stemming from high unemployment rates (which peaked at 25 percent in 1933-34) as well as worsening income disparities regarding access to health care. In addition, due to constantly increasing medical costs, sickness was becoming a main cause of poverty. As a result, physicians and hospitals often went unpaid, leaving welfare agencies the task of helping the poor with their medical bills (Hoffman, 2009), which created incentives for the development of plans to allow people to pay for hospital care. The Baylor Plan, developed at Baylor University Hospital in 1932 by Justin Kimble, was the first such plan. By 1933, there were 26 such hospital service plans in the country, which represented the precursors to the Blue Cross and Blue Shield plans that exist in most states today (Morrisey, 2007).

World War II gave impetus to the spread of health insurance coverage, which increased from 9 percent of the population at the start of the war to almost 23 percent by the war's end. Three key reasons for this development were the wage and price controls put in place by the government during the war, the increase in labor union power, and a private ruling by the Internal Revenue Service that employer-sponsored health insurance should not be subject to federal income taxation, a situation formally enacted into law by Congress in 1954 (Morrisey Ch. 1, 2007). The latter factor helped businesses circumvent the wage controls and attract labor by offering workers a health insurance package. By 1950, the percentage of Americans with some form of private health insurance had doubled, reaching nearly 70 percent by 1960 (Lichtenstein, 2022).

The 1960s saw the next significant development in publicly funded health care coverage with the creation of the Medicare and Medicaid programs. It took a landslide victory by Lyndon Johnson and the Democrats in 1964 to transform the growing support of Congressional Democrats in the 1950s for health coverage for the elderly into a concrete result (Hoffman, 2009). Medicare and Medicaid were signed into law by Johnson in July of 1965 as part of the Social Security Act and Johnson's Great Society program (see below for more on the specific nature of these two programs).

## 4 – The health insurance landscape post-1970: Erisa, Managed Care Programs, and Obamacare

Fast forward to 1974, an important moment from a regulatory standpoint with the passage of ERISA (the Employee Retirement Income Security Act). Designed mainly to protect company pension plans after the closure of the Studebaker Corporation automobile plant in 1963 had

resulted in an underfunded pension plan, ERISA also had some important implications for employer health plans. Companies with self-insured health plans for their employees that chose to take part in ERISA were not subject to a uniform federal ERISA statute and no longer to a myriad of different state regulations. In addition, they were also no longer required to pay state taxes on insurance premiums. ERISA was responsible for the "growth of self-insured employer health plans and all but ensured competition in the risk-bearing segment of the conventional insurance market" (Morrisey, 2007).

A major phase in health care coverage began in the 1970s in the form of managed care using provider networks, spurred by rising health care costs due in large part to advances in medical technology and the greater reliance by insurers and Medicare on "cost-based reimbursement systems". These are systems where the provider is reimbursed for the costs incurred in the service, as opposed to "allowable cost systems", where the provider receives the amount the insurer has agreed to cover, with any shortfall paid out-of-pocket by the beneficiary (Morrisey, 2007).

Managed care programs embodied features of the prototype health insurance plans from earlier in the 20th century (Lichtenstein, 2022). The three main types of managed care programs are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service plans (POS) (see below for a more detailed description of these plans). Although prototypes of HMOs date back to 1910, the first true HMO is considered to have been created in 1929. HMOs gained new impetus when, in 1971, the Nixon administration endorsed them as the new national health strategy (Gruber *et al*., 2008).

A final key moment in this brief survey of health insurance programs came in 2010 with the passage of the Patient Protection and Affordable Care Act (ACA), which guarantees any insured American minimum levels of coverage with a ceiling on costs (see below for a more detailed description) (Lichtenstein, 2022).

## 5 – Medicare and Medicaid

As mentioned above, Medicare and Medicaid were signed into law by Lyndon Johnson in 1965. Two key factors laid the groundwork for these programs. The first is tied to the difference between "experience-based rating" and "community rating", both of which are used by insurance companies to determine premiums. Under the latter, the premiums charged by insurance companies are the same for everyone, no matter the level of risk. As time went on, insurers turned more to experience-based rating, which offered better premiums to lower-risk groups, such as younger and healthier individuals and those less likely to suffer injuries. This development disadvantaged the elderly, retired individuals, and the disabled (Lichtenstein, 2022). The second important factor was the election of 1964, which resulted in a resounding victory by the Democrats and control of both houses of Congress. This allowed Johnson to overcome the opposition to health insurance reform by a conservative coalition of Republicans and Southern Democrats (Oberlander, 2003). The latter group was particularly concerned because the desegregation features of the measures regarding waiting rooms, hospital floors, and physician practices ran counter to their segregationist policies (Sternberg, 2015). President Johnson also had to deal with opposition from other stakeholders, such as the American Hospital Association (AHA), the American Medical Association (AMA), and the general stigma that has always existed in the country toward "socialism", and in this case "socialized medicine"

(Oberlander, 2003). The result was a layered plan that reflected an appeasement of these various interests.

Traditional Medicare is a “fragmented program”, with Part A covering hospital care and Part B outpatient services. For prescription drug coverage, patients must enrol in a separate Part D plan administered by private insurers. In most cases, individuals also purchase supplemental coverage to limit their out-of-pocket costs (Scott, 2023). Medicare Part A, which includes hospital and limited nursing home coverage, was backed by the AHA and trade unions. The AHA was concerned about the difficulty for the elderly and other segments of the population to meet their hospital needs due to a reliance by insurers on experience-based rating. From the unions' perspective, there were several advantages of Medicare. The Medicare program would be based on Social Security eligibility and funded by payroll, not income, taxes. “Eligibility based on Social Security participation, rather than a low-income standard of eligibility, meant that high-income union members would be eligible. The payroll tax meant that the costs would be disproportionately borne by lower income, non-union, workers” (Morrisey, 2007). In addition, since many health care expenditures would be paid by the government and not the employers, the unions would have more latitude to negotiate for higher wages. With original Medicare, most of the costs of health care services and supplies are covered, although the beneficiary does have to pay a deductible. Beneficiaries can go to any hospital or physician that accepts Medicare.

Whereas Part A covers hospital insurance, Part B provides medical insurance, encompassing voluntary outpatient physician coverage (Lichtenstein, 2022). Part B encompasses medically necessary services, which are “services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice” and preventive services, which involve “health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best” (Medicare.gov, What Part B covers, 2023).

Under Medicare Advantage, also known as Part C, private insurers can offer plans that provide Medicare benefits, as well as some additional services not included in the original program. “Medicare Advantage combines all of these benefits into one insurance plan that also includes an annual limit on out-of-pocket costs, something that does not technically exist in regular Medicare” (Dylan, 2023). There is a yearly limit for Part C out-of-pocket costs: MOOP, or the maximum out-of-pocket amount. The MOOP for 2024 is $8,850, although the various insurance plans have the discretion to set lower limits (Medicare Interactive, 2024). To join Medicare Advantage, an individual must have enrolled in both Plan A and Plan B, the latter of which requires payment of a premium (Medicare.gov, How does Medicare work, 2023). Today, Medicare is funded mainly from general tax revenues (46%), payroll tax revenues (34%), and premiums paid by beneficiaries (15%) (Cubanski & Neuman, 2023).

The Social Security Act of 1965 also created Medicaid, which is a federal and state entitlement program (a program that grants rights to certain citizens and non-citizens under federal law). Jointly funded by the state and federal governments, Medicaid provides medical assistance to families with low incomes or few resources, and it “represents the largest source of funding for medical and health-related services for America’s poorest people” (Klees *et al*., 2015). Although the federal statutes set the general guidelines for the program, the eligibility standards and scope of services are determined by the states, so that an individual might be eligible for certain services in one state but not in another (Klees *et al*., 2015). Other related programs for health care for the poor that were subsequently created include the State Children's Health Insurance Program (SCHIP) in 1997, as Title XXI of the Social Security Act,

for low-income children. SCHIP later became the Children's Health Insurance Program (CHIP). States have the option under CHIP to provide coverage to eligible children by expanding their Medicaid programs or through a separate state program (Klees *et al*, 2015).

## 6 – Managed care programs: HMOs, PPOs, and POS

As mentioned above, managed care programs began to spread in the 1970s due to rising health care costs. The three main types – HMOs, PPOs, and POS – all have features in common but differ in the amount of flexibility offered to subscribers of the plans in choosing their health care providers and in the comprehensiveness of the coverage, which translate into differences in the amount paid for deductibles and premiums.

A Health Maintenance Organization charges a fixed yearly fee for managed care to different entities, including health insurers, self-funded health care benefit plans, and individuals. HMOs have pre-paid relationships with medical professionals (doctors, hospitals) (Falkson & Srinivasan, 2023). An HMO is an insurance company, and therefore it bears claims and has underwriting risk (Morrisey, 2007). Subscribers to an HMO must use medical providers within the network and choose a Personal Care Physician (PCP), from whom they must obtain a referral before visiting a specialist. Under a Point of Service plan, subscribers may turn to an out-of-network doctor for slightly higher premiums and may require a referral from a PCP before visiting a specialist (Aetna, 2023). Finally, a Preferred Provider Organization (PPO) offers the most flexibility to the subscriber. With this plan, in exchange for higher premiums, it is not necessary to get a referral to see a specialist or out-of-network doctor. In the event an individual chooses an in-network doctor, co-pays and coinsurance payments (the amount not covered by the insurance plan that the individual pays) are low (Aetna, 2023).

## 7– The Affordable Care Act (Obamacare)

The Patient Protection and Affordable Care Act (the Affordable Care Act (ACA), or simply Obamacare) became law in March 2010, providing health insurance to millions of uninsured Americans. The ACA has three main objectives: to extend the availability of affordable health insurance to more people by providing subsidies in the form of "premium tax credits" for households whose incomes are between 100% and 400% of the federal poverty level (FPL); to extend Medicaid eligibility to all adults with incomes below 138% of the FPL; and to "support innovative medical care delivery methods designed to lower the costs of health care generally" (Healthcare.gov).

Among its key provisions, the ACA expanded eligibility for Medicaid by encouraging states to provide Medicaid for parents and those without dependent children whose incomes are less than 138% of the federal poverty level. States that participated in the program would receive 100% of the cost for eligibility expansion for three years, followed by a gradual decrease in federal funding down to 90% in 2020 (Lyon *et al*., 2014). Recently, North Carolina became the 40th state to expand Medicaid under this program (Richardson, December 2023). In addition, the ACA set up a Health Insurance Marketplace (a platform offering insurance plans to individuals, families, and small businesses (Kagan, 2022)) and prohibited insurance companies from withholding coverage for individuals with pre-existing conditions. Low-income individuals and families are offered tax deductions on premiums and cost-sharing reductions, and insurers are required to cover certain essential health benefits, such as emergency services, family planning, maternity care, hospitalization, prescription medications, mental health services, and

pediatric care, as well as provide a list of preventive services free of charge to policyholders, which include checkups, patient counseling, immunizations, and numerous health screenings Finally, states have the option of extending Medicaid to a broader group of people (Kagan, 2022).

## 8 –Stops and starts along the road to more comprehensive health insurance

Beginning with the Progressive Era at the end of the 19th century, the need for more comprehensive health insurance coverage became a constant element of the political and social discourse in the U.S. More than a century later, it remains a hot-button issue that arguably represents the most important concern for everyday Americans. The shifting economic, social, ideological, demographic, and technological backdrop continues to inform the focus of the health care coverage debate.

The developments over the years regarding comprehensive health care have often been characterized by stops and starts that reflect changing political landscapes, shifting and evolving positions by major stakeholder groups, such as the AMA, AHA, and labor unions, ideological resistance, and even sociological issues regarding segregation. Industrialization represented the initial impetus for measures aimed at providing workers with health care protection. The changing nature of industrial activities meant increasing workplace risks for workers and tore away at traditional support structures at the family and community level (Bump, 2015). The Progressive Era witnessed a series of legislation regarding social protection that later would encompass the "sickness funds" set up by employers or unions, which loosely speaking entailed sick pay for workers. Progressive Era reformers subsequently advocated for government health schemes due to deficiencies in the sickness funds (Bump, 2015).

Emblematic of the difficulties in gaining broad-based support for health care reform was the bill crafted by the American Association of Labor Legislation (AALL) in 1915, which included health care services, sick pay, maternity benefits, and a death benefit. This bill was opposed by groups one would normally think would be fervent supporters of it, such as organized labor, with the American Federation of Labor (AFL) viewing it as "an unnecessary paternalistic reform that would create a system of state supervision over people's health…[and as] a government-based insurance system [that] would weaken unions by usurping their role in providing social benefits" (Palmer, 1999). This position by the AFL was an instance where its self-interest worked to the detriment of the constituents it was meant to serve. Similarly, the AMA withdrew its initial support of the bill from concerns over how physicians would be paid under the plan. In the past, physician groups had defended their lukewarm stance toward government-funded insurance by emphasizing their support of voluntary insurance plans and the practice of charging patients on a sliding scale. However, many well-known economists have countered the latter claim by stating that the medical profession is, in fact, a monopoly that uses the sliding scale as a form of price discrimination to maximize profits (Kessel, 1958). There was also opposition from the private health insurance companies, who felt threatened by the prospect of the government taking away from their business through the funeral expense provision of the bill (Palmer, 1999).

WWI and its aftermath slowed down any real progress on government-funded health care: articles commissioned by the government railed against "German socialist insurance", and "opponents of compulsory health insurance associated it with Bolshevism, burying it in an

avalanche of anti-Communist rhetoric. This marked the end of the compulsory national health debate until the 1930's" (Palmer, 1999).

As noted above, during FDR's presidency, an expansion in private health insurance plans began that ran up to the early 1960s and Lyndon Johnson's Social Security Act. However, somewhat paradoxically, the Great Depression did not lead to compulsory health insurance in the country. Because of the millions of workers who found themselves out of work, the main priority became unemployment insurance and old age benefits. FDR and his advisors were concerned that including health insurance in the Social Security Bill, which the AMA opposed, would jeopardize the passage of the entire legislation (Palmer, 1999).

There were some attempts at more comprehensive government health care during the war years, which, however, never got off the ground. The Wagner National Health Act of 1939 (sponsored by NY Democratic Senator Robert F. Wagner) grew out of work by the Tactical Committee on Medicare set up by FDR in 1937. The bill "created federal funding to states for expanding public health, maternal and child health services, medical care for the low-income, short-term disability insurance, hospital construction, and prepaid medical insurance" (Healthcare-Now, 2023). The states would have been allowed to use the funds for universal or mandatory health insurance programs and given broad discretion in administering the funds (Healthcare-Now, 2023). However, strong Republican gains in the 1938 off-year elections doomed passage of the legislation. The Wagner Bill evolved into another ill-fated reform, the Wagner-Murray-Dingell Bill of 1943, which would have led to compulsory national health insurance and a payroll tax. The Bill engendered considerable national debate, with opponents engaging in "red-baiting" to help derail its passage. It was re-presented in every Congressional session for the next 14 years without success (Palmer, 1999).

In many ways, the universal health care plan supported by Harry Truman was the precursor to Lyndon Johnson's Social Security Act and Obamacare. Unlike FDR's plan, Truman's plan "was strongly committed to a single universal comprehensive health insurance plan. Whereas FDR's 1938 program had a separate proposal for medical care of the needy, it was Truman who proposed a single egalitarian system that included all classes of society, not just the working class" (Palmer, 1999). Under the plan, individuals would pay a monthly amount in fees and taxes to finance the program. However, any chances of passage were wrecked by a combination of factors: the continued Communist paranoia during the Cold War, claims (largely by the AMA) that the bill would give the government too much control, and Republicans regaining control of the House of Representatives in 1946 (Harry S. Truman Library and Museum, 2023).

As outlined above, the watershed moment for government-funded health coverage was the passage of the Social Security Act in 1965 during the Lyndon Johnson administration. The supermajorities won by the Democrats in the House of Representatives and Senate enabled Johnson to build on the momentum from the 1950s for extending health insurance coverage for Social Security beneficiaries, most of whom were elderly. Responding to John F. Kennedy's support for Medicare, the AMA had responded by saying that "Medicare would put the government smack into your hospital". At the same time, Ronald Reagan warned that the government would use medicine to "[impose] statism or socialism on a people" (Zelizer, 2015). Johnson was able to overcome the opposition of the AMA with the compromise feature that it would not be the government that would regulate prices for medical services but the hospitals and doctors that would determine the "reasonable charges" for costs (Zelizer, 2015).

## 9 – Conclusion

Developments in both private and government-funded health insurance in the U.S. have been constantly evolving since the Progressive Era. The Progressive Era represented a period when fast-paced urbanization and industrialization at the end of the 19th century set in motion economic and social evolutions necessitating a new set of responses that entailed a rejection of Social Darwinism as a remedy to an array of social problems, including poor health (Paul, 2017).

Health care policy has been influenced by economic, social, political, and ideological factors, with competing interests and stakeholders sometimes acting in their self-interest. These factors go a long way in explaining the uneven development that has taken place in this area. In addition to illustrating the main elements of government-funded and private health insurance, this article has attempted to present the various phases of health care reforms as an outgrowth of the specific societal factors at play at that moment. Future treatment of this topic might start from this overview to delve more deeply into these factors to assess the relative weights each has played, and will likely continue to play, in the specific American context. This same societal panoply could be used to try and predict future developments in health care coverage, although given the more transitory nature of political, economic, and social tendencies any such attempt would best be limited to the short- to medium-term. Another research implication from this paper could be an examination of how calamitous events such as COVID-19 or a severe economic recession might be a catalyst for more radical changes in attitudes and policy regarding comprehensive health care.

Limitations for further research reflect the nature of the topic itself. Absent historical determinism as a guidepost, a reliance on historical analysis to predict future developments will necessarily be fraught, as unforeseen events can occur that can significantly alter current trajectories in public policy. However, at the same time, this does not mean the researcher must throw up his or her hands and profess academic impotence in mapping out future developments.

Social protection systems began to expand in Western Europe and the U.S. during the first quarter of the 20th century, and although there were contextual and programmatic similarities, the mix and timing of the solutions that emerged were specific to each country. For example, as noted above, the U.S. had to deal with the unique obstacle of a continued and general ideological wariness of any program portrayed as "socialistic" by the opposition; the negative influence of segregationist forces in the South; and the opposition at times from labor unions, hospitals, physicians, and the insurance sector because of the particular position of these groups in the country.

Conservatives continue to advocate for the removal of Obamacare without providing a detailed plan for the 40 million Americans who would thereby lose their health insurance. Nevertheless, there are many problems to resolve moving forward regarding health care and health insurance in the U.S.: the percentage of the population that is uninsured and underinsured is still too high; the prices for health care services remain far too high and often too variable; health insurers at times discourage certain medications, treatments, and services to limit costs; the fragmented settings for health care in the U.S. "can lead to duplication of care, poor coordination of services, and higher costs" (Shmerling, 2021); and the system is "beset with inequalities that have a disproportionate impact on people of color and other marginalized groups…[which] contribute to gaps in health insurance coverage, uneven access to services, and

poorer health outcomes among certain populations" that disproportionately affect African Americans (Taylor, J., 2019).

On a positive note, the percentage of uninsured Americans is reaching historic lows, due in part to policy initiatives during the COVID-19 pandemic and the continued expansion by states of Medicaid eligibility under the ACA. However, this situation is tempered by the fact that 43% of working-age Americans had inadequate health insurance in 2022, with the prospects for a worsening of this situation as some temporary pandemic measures expire (Collins *et al.*, 2022). There is no end of the road when it comes to government-funded social insurance policies, as each historical phase presents its unique problems and requirements for reform. Future generations may look back at the COVID-19 period as the start of a new phase in health care in the U.S. To create an environment for a well-thought-out, effective, and equitable health care system, it is necessary to replace the extreme polarization of the political landscape in America with one characterized by "the trust, will, and vision necessary to build something better" (Shmerling, 2021).

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